		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019166

Facility Name: Pleasant Meadows Christian Village

Address: 400 West Washington (Number) Chrisman (City) 61924 (Zip Code)

County: Edgar

Telephone Number: 217-269-2396 **Fax #** ( )

IDPA ID Number: 37-0841562001

Date of Initial License for Current Owners: 1974

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501c3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2002 to June 30, 2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer
(Signed) (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/22/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,661	5,191	860	18,712	8
9	SNF/PED					9
10	ICF	5,273	6,669		11,942	10
11	ICF/DD					11
12	SC	2,576	5,639		8,215	12
13	DD 16 OR LESS					13
14	TOTALS	20,510	17,499	860	38,869	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.70%

D. How many bed-hold days during this year were paid by Public Aid? 150 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 109 and days of care provided 860

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	187,476	22,339	7,899	217,714		217,714		217,714			1
2	Food Purchase		206,639		206,639		206,639	(667)	205,972			2
3	Housekeeping	161,321	37,774		199,095		199,095		199,095			3
4	Laundry											4
5	Heat and Other Utilities			150,189	150,189		150,189	2,559	152,748			5
6	Maintenance	45,415	17,148	28,620	91,183		91,183	7,917	99,100			6
7	Other (specify):*											7
8	**TOTAL General Services**	394,212	283,900	186,708	864,820		864,820	9,809	874,629			8
	B. Health Care and Programs											
9	Medical Director			1,440	1,440		1,440		1,440			9
10	Nursing and Medical Records	1,573,807	105,434	4,781	1,684,022		1,684,022	(2,096)	1,681,926			10
10a	Therapy			116,562	116,562		116,562		116,562			10a
11	Activities	34,516	3,863	7,996	46,375		46,375	459	46,834			11
12	Social Services	88,482			88,482		88,482		88,482			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,696,805	109,297	130,779	1,936,881		1,936,881	(1,637)	1,935,244			16
	C. General Administration											
17	Administrative	131,124		194,398	325,522		325,522	(146,468)	179,054			17
18	Directors Fees											18
19	Professional Services			3,604	3,604		3,604	6,769	10,373			19
20	Dues, Fees, Subscriptions & Promotions			20,421	20,421		20,421	(814)	19,607			20
21	Clerical & General Office Expenses	70,478	10,785	42,960	124,223		124,223	49,635	173,858			21
22	Employee Benefits & Payroll Taxes			427,997	427,997		427,997	18,815	446,812			22
23	Inservice Training & Education											23
24	Travel and Seminar			20,943	20,943		20,943	6,413	27,356			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			95,686	95,686		95,686	2,827	98,513			26
27	Other (specify):*											27
28	**TOTAL General Administration**	201,602	10,785	806,009	1,018,396		1,018,396	(62,823)	955,573			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,292,619	403,982	1,123,496	3,820,097		3,820,097	(54,651)	3,765,446			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Pleasant Meadows Christian Village #0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			154,138	154,138	(407)	153,731	25,156	178,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			131	131		131		131			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			154,269	154,269	(407)	153,862	25,156	179,018			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			266	266		266		266			39
40	Barber and Beauty Shops	22,380	1,503		23,883		23,883		23,883			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,677	59,677		59,677		59,677			42
43	Other (specify):* Apt/Cong & Other			32,677	32,677	407	33,084		33,084			43
44	**TOTAL Special Cost Centers**	22,380	1,503	92,620	116,503	407	116,910		116,910			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,314,999	405,485	1,370,385	4,090,869		4,090,869	(29,495)	4,061,374			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(996)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,180)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(2,096)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	13,396	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,044)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(318)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,855)	21		24
25	Fund Raising, Advertising and Promotional	(814)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(3,399)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (7,306)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(22,189)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (22,189)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (29,495)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Pleasant Meadows Christian Village

ID# 0019166

Report Period Beginning: July 1, 2002

Ending: June 30, 2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 329	2	1
2	Activity	459	11	2
3	Marketing	(2,182)	21	3
4	Loss on Disposal	(2,690)	21	4
5	Miscellaneous	685	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,399)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pleasant Meadows Christian Village **#** 0019166 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(667)	0	0	0	0	0	0	0	0	0	0	(667)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,180)	4,739	0	0	0	0	0	0	0	0	0	2,559	5
6	Maintenance	0	7,917	0	0	0	0	0	0	0	0	0	7,917	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,847)	12,656	0	0	0	0	0	0	0	0	0	9,809	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,096)	0	0	0	0	0	0	0	0	0	0	(2,096)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	459	0	0	0	0	0	0	0	0	0	0	459	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,637)	0	0	0	0	0	0	0	0	0	0	(1,637)	16
	C. General Administration													
17	Administrative	685	(147,153)	0	0	0	0	0	0	0	0	0	(146,468)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,769	0	0	0	0	0	0	0	0	0	6,769	19
20	Fees, Subscriptions & Promotions	(814)	0	0	0	0	0	0	0	0	0	0	(814)	20
21	Clerical & General Office Expenses	(16,089)	65,724	0	0	0	0	0	0	0	0	0	49,635	21
22	Employee Benefits & Payroll Taxes	0	18,815	0	0	0	0	0	0	0	0	0	18,815	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,413	0	0	0	0	0	0	0	0	0	6,413	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,827	0	0	0	0	0	0	0	0	0	2,827	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(16,218)	(46,605)	0	0	0	0	0	0	0	0	0	(62,823)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,702)	(33,949)	0	0	0	0	0	0	0	0	0	(54,651)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Pleasant Meadows Christian Village** **#** **0019166** **Report Period Beginning:** **July 1, 2002** **Ending:** **June 30, 2003**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,396	11,760	0	0	0	0	0	0	0	0	0	25,156	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	13,396	11,760	0	0	0	0	0	0	0	0	0	25,156	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(7,306)	(22,189)	0	0	0	0	0	0	0	0	0	(29,495)	45

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes Inc	100.00%	$ 4,739	$ 4,739	1
2	V	6	Maintenance				7,917	7,917	2
3	V	17	Administrative	191,844			44,691	(147,153)	3
4	V	18	Directors						4
5	V	19	Professional Services				6,769	6,769	5
6	V	20	Fees, Subscriptions						6
7	V	21	Clerical				65,724	65,724	7
8	V	22	Employee Benefits				18,815	18,815	8
9	V	23	Inservice Training						9
10	V	24	Travel & Seminar				6,413	6,413	10
11	V	26	Insurance				2,827	2,827	11
12	V	30	Depreciation				11,760	11,760	12
13	V								13
14	Total			$ 191,844			$ 169,655	$ * (22,189)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: ne 30, 2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	This workpaper is not applicable.											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pleasant Meadows Christian Village COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0019166

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-03-26-400-021	S26-T16-R12	$ 55.76	$
2.	11-03-26-300-014	S26-T16-R12	$ 79.06	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 134.82	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	435,600	1971	$ 15,876	1
2	Home Office Allocation			6,361	2
3	TOTALS	435,600		$ 22,237	3

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	109		1975	1975	$ 1,305,939	$ 30,697	40	$ 32,648	$ 1,951	$ 867,066	4
5					228,890		20	11,445	11,445		5
6			2000	2000	1,235,805	41,194	30	41,194		144,179	6
7											7
8	Home Office Allocation				45,873	1,319		1,319		23,691	8
	Improvement Type**										
9	Building Improvements			1979	3,855	84	46	84		2,058	9
10	Building Improvements			1980	533	12	44	12		276	10
11	Blank										11
12	Building Improvements			1982	20,257		20			20,257	12
13	Contractor A/C			1985	4,298		15			4,298	13
14	Sewer Repairs			1986	2,310	116	20	116		1,924	14
15	Condensing Unit A/C			1986	3,015		10			3,015	15
16	Building Improvements			1987	450		10			450	16
17	Building Improvements			1987	18,430	302	15	302		18,430	17
18	Building Improvements			1987	2,258		10			2,258	18
19	Building Improvements			1987	800	40	20	40		637	19
20	Building Improvements			1987	312		10			312	20
21	Building Improvements			1988	1,314		10			1,314	21
22	Building Improvements			1988	3,234		10			3,234	22
23	Building Improvements			1988	3,250	194	15	194		3,250	23
24	Building Improvements			1988	20,978	1,275	15	1,275		20,978	24
25	Phone Lines			1989	1,193		10			1,193	25
26	Wallcovering			1989	2,957		5			2,957	26
27	Wallcovering			1990	1,594		5			1,594	27
28	Reroof Portion of NH			1990	11,305	754	15	754		9,865	28
29	Rail/Baseboard			1990	775		10			775	29
30	Wallcovering			1990	1,835		5			1,835	30
31	Wallcovering			1991	1,835		5			1,835	31
32	Wallcovering			1991	5,136		5			5,136	32
33	Rail/Baseboard			1991	744	37	20	37		456	33
34	Wallcovering			1991	848		5			848	34
35	Remodeling				2,996	150	20	150		1,838	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof	1991	$ 8,000	$ 533	15	$ 533	$	$ 6,307	37
38	Remodeling	1991	1,720	86	20	86		1,011	38
39	Wallcovering	1991	3,854		5			3,854	39
40	Sprinkler System	1991	602	40	15	40		463	40
41	Remodeling	1992	5,488	275	20	275		3,171	41
42	Remodeling	1992	6,610	331	20	331		3,768	42
43	Carpeting	1992	4,115		5			4,115	43
44	Carpeting	1992	8,647		5			8,647	44
45	Door	1992	551	37	15	37		407	45
46	Roof	1992	11,500	767	15	767		8,309	46
47	Carpeting	1992	806		5			806	47
48	Wallcovering	1992	3,384		5			3,384	48
49	Wallcovering	1993	3,081		5			3,081	49
50	Carpeting	1993	5,093		5			5,093	50
51	A/C System	1993	11,333	756	15	756		7,623	51
52	Sink	1993	2,199	201	10	201		2,199	52
53	Roof-NE/Gutters	1993	15,680	1,045	15	1,045		10,363	53
54	Gutters	1993	990	66	15	66		644	54
55	Baseboard/Wallcoverings	1993	9,755		5			9,755	55
56	10 Ton A/C Unit	1994	9,817	654	15	654		5,940	56
57	Roof Hall	1994	9,600	640	15	640		5,653	57
58	Roof Top	1994	15,088	1,006	15	1,006		8,886	58
59	Gutters	1994	934	93	10	93		814	59
60	Rooftop A/C	1994	44,062	2,937	15	2,937		25,454	60
61	Tile Bathrooms	1995	673		5			673	61
62	Kitchen Exhaust Fan	1995	1,680	168	10	168		1,369	62
63	Rooftop A/C	1995	7,197	720	10	720		5,880	63
64	Bathroom Motion Light	1995	7,299	730	10	730		5,962	64
65	Ceramic Tile shower	1995	7,546	755	10	755		6,103	65
66	Skylight Dining Room	1995	6,785	679	10	679		5,375	66
67	Fire Alarm	1995	1,222	122	10	122		946	67
68	Wallcoverings	1996	3,300		5			3,300	68
69	Fire Alarm	1996	17,700	1,770	10	1,770		12,833	69
70	TOTAL (lines 4 thru 69)		$ 3,169,330	$ 90,585		$ 103,981	$ 13,396	$ 1,318,147	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,169,330	$ 90,585		$ 103,981	$ 13,396	$ 1,318,147	1
2	Termite system	1996	11,000	220	20	220		2,622	2
3	Gutters	1996	6,258	626	10	626		4,173	3
4	Kick plates	1997	2,743	274	10	274		1,781	4
5	Wallcoverings	1997	3,290		5			3,290	5
6	Energy Management System	1997	15,018	1,502	10	1,502		9,262	6
7	Ventilation Fan	1997	2,167	217	10	217		1,284	7
8	Wallcoverings	1998	8,455	986	5	986		8,455	8
9	Rubber Roof Skylight	1998	3,100	465	5	465		3,100	9
10	Floor-Therapy room	1998	972	180	5	180		972	10
11	Water Heater	1999	4,139	69	30	69		1,449	11
12	Fire Dampers	1999	7,952	795	10	795		3,445	12
13	Alarm System	2000	1,152	115	10	115		460	13
14	Quarry Tile	2000	2,033	407	5	407		1,560	14
15	Deck	2000	1,271	254	5	254		783	15
16	AC 3 TON	2000	1,200	240	5	240		720	16
17	DECK	2000	719	144	5	144		432	17
18	WINDOW	2000	2,150	215	10	215		609	18
19	WALLCOVERINGS	2000	2,792	558	5	558		1,442	19
20	Waterline and drain	7/5/2001	4,225	845	5	845		1,690	20
21	Smoke Detection Unit	11/29/2001	2,143	214	10	214		357	21
22	Rubber Roof (Northeast Section)	10/24/2001	7,737	774	10	774		1,355	22
23	Smoke Detector	12/13/2001	3,452	345	10	345		546	23
24	Windows	12/6/2001	1,923	128	15	128		203	24
25	Build/Install/Finish Fire Doors/Walls	1/14/2002	19,377	969	20	969		1,454	25
26	Install Window at Front Reception Desk	3/29/2002	967	64	15	64		85	26
27	Implementation of New Structured CAT5E Wiring	4/27/2002	1,790	90	20	90		113	27
28	Remove/Hang Wall paper-Beauty Shop Hallway	6/3/2002	1,124	112	10	112		121	28
29	65 Gallon AO Smith Water Heater	9/18/2002	3,900	325	10	325		325	29
30	(6) 11,800 btu A/C units w/wall sleeve	11/30/2002	4,016	268	10	268		268	30
31	Sanyo Condensing Unit & Evaporator	6/5/2003	1,100	9	10	9		9	31
32	Install High EFF Ballast Lights	6/27/2003	23,404	195	10	195		195	32
33	EZ Barn	5/20/1993	1,891	126	15	126		614	33
34	TOTAL (lines 1 thru 33)		$ 3,322,790	$ 102,316		$ 115,712	$ 13,396	$ 1,371,321	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,322,790	$ 102,316		$ 115,712	$ 13,396	$ 1,371,321	1
2	Garage	7/1/1999	19,001	475	40	475		1,900	2
3	Shed	4/3/2000	1,510	151	10	151		1,019	3
4	Fully depreciated land improvements	6/30/1978	38,077		20			38,077	4
5	Concrete and dirt work	8/31/1984	4,779	239	20	239		4,501	5
6	Landscaping	6/30/1986	6,549	327	20	327		5,586	6
7	Block shute & Structure	10/6/1988	2,725	136	20	136		2,006	7
8	Resurface parking lot	6/30/1989	23,325	1,555	15	1,555		21,900	8
9	Landscaping	6/30/1991	3,702	185	20	185		2,258	9
10	Landscaping & trees	7/6/1993	2,600	130	20	130		1,332	10
11	Gazebo & Fence	1/5/2000	9,884	988	10	988		3,952	11
12	Landscaping	11/8/1999	9,303	930	10	930		3,410	12
13	Seal Asphalt	7/28/2000	3,010	376	8	376		1,128	13
14	Landscaping, fence, flowers & grass	10/17/2000	8,052	805	10	805		2,532	14
15	Replace sidewalk	11/26/2001	665	67	10	67		168	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Less: Disposals		(4,139)					(1,449)	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,451,833	$ 108,680		$ 122,076	$ 13,396	$ 1,459,641	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 376,658	$ 43,331	$ 43,331	$	Various	$ 196,723	71
72	Current Year Purchases	38,460	3,039	3,039		Various	3,039	72
73	Fully Depreciated Assets	295,670				Various	295,670	73
74	Home Office Allocation	79,612	8,429	8,429			44,076	74
75	TOTALS	$ 790,400	$ 54,799	$ 54,799	$		$ 539,508	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1994 Ford Bus	1994	$ 43,500	$	$	$	8	$ 43,500	76
77										77
78	Home Office Allocation			9,172	2,012	2,012			4,209	78
79										79
80	TOTALS			$ 52,672	$ 2,012	$ 2,012	$		$ 47,709	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,317,142	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 165,491	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,887	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,396	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,046,858	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment	$ 95,951	$ 2,691	$ 69,231	86
87	Independent Living	446,267	13,492	227,895	87
88	Land	24,818			88
89					89
90					90
91	TOTALS	$ 567,036	$ 16,183	$ 297,126	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 97

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 42

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		191	337		528
3	Classroom Wages	(a)	3,064	5,422		8,486
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	4,025	7,123		11,148
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			1,150		1,150
9	TOTALS		$ 7,280	$ 14,032	$	$ 21,312
10	SUM OF line 9, col. 1 and 2	(e)	$ 21,312			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	13
2. From other facilities (f)	
TOTAL TRAINED	36

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Pleasant Meadows Christian Village **#** 0019166 **Report Period Beginning:** July 1, 2002 **Ending:** June 30, 2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 584,462	$	1
2	Cash-Patient Deposits	8,718		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,714)	393,751		3
4	Supply Inventory (priced at FIFO)	20,703		4
5	Short-Term Investments	579,362		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	20,032		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,607,028	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,694		13
14	Buildings, at Historical Cost	3,815,384		14
15	Leasehold Improvements, at Historical Cost	112,671		15
16	Equipment, at Historical Cost	774,405		16
17	Accumulated Depreciation (book methods)	(2,272,143)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,367,822		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,838,833	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,445,861	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,603	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,718		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	196,481		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	202		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 281,004	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 281,004	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,164,857	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,445,861	$	48

***(See instructions.)**

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,214,984	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,214,984	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	349,869	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 349,869	17
	B. Transfers (Itemize):		
18	**Transfer Out to Affiliate**	(399,996)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (399,996)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,164,857	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,794,653	1
2	Discounts and Allowances for all Levels	(871,859)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,922,794	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,022	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 148,022	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,277	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	27,315	13
14	Non-Patient Meals	996	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,843	19
20	Radiology and X-Ray	399	20
21	Other Medical Services	(828)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 36,002	23
	D. Non-Operating Revenue		
24	Contributions	98,354	24
25	Interest and Other Investment Income***	114,286	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 212,640	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Resident/Congregate	110,641	28
28a	Unrealized G(L) on Investment/Sale of Equipment	10,639	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 121,280	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,440,738	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	864,820	31
32	Health Care	1,936,881	32
33	General Administration	1,018,396	33
	B. Capital Expense		
34	Ownership	154,269	34
	C. Ancillary Expense		
35	Special Cost Centers	56,826	35
36	Provider Participation Fee	59,677	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,090,869	40
41	**Income before Income Taxes (line 30 minus line 40)****	349,869	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 349,869	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,686	1,839	$ 36,727	$ 19.97	1
2	Assistant Director of Nursing	1,623	1,751	32,029	18.29	2
3	Registered Nurses	10,755	11,547	262,621	22.74	3
4	Licensed Practical Nurses	24,158	24,719	393,220	15.91	4
5	Nurse Aides & Orderlies	76,523	81,508	809,795	9.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,442	3,703	39,416	10.64	8
9	Activity Director	1,766	1,815	22,781	12.55	9
10	Activity Assistants	1,053	1,084	11,735	10.83	10
11	Social Service Workers	8,455	8,680	88,482	10.19	11
12	Dietician					12
13	Food Service Supervisor	1,740	1,991	29,996	15.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,253	17,569	157,480	8.96	15
16	Dishwashers					16
17	Maintenance Workers	2,768	2,807	45,415	16.18	17
18	Housekeepers	16,074	16,492	161,321	9.78	18
19	Laundry					19
20	Administrator	3,170	3,351	131,124	39.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,762	1,862	43,695	23.47	23
24	Clerical	1,637	1,727	26,782	15.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,811	2,203	22,380	10.16	33
34	TOTAL (lines 1 - 33)	174,676	184,648	$ 2,314,999 *	$ 12.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	169	$ 7,899	1.3	35
36	Medical Director	120	1,440	9.3	36
37	Medical Records Consultant	22	691	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	1,539	10.3	39
40	Physical Therapy Consultant	1,315	86,960	10A.3	40
41	Occupational Therapy Consultant	164	12,144	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	264	17,458	10A.3	43
44	Activity Consultant	84	7,327	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,258	$ 135,458		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Vincent	Administrator	0	$ 96,140
Lucinda Kime	Administrator	0	34,984
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,124

B. Administrative - Other

Description	Amount
Management Fee	$ 191,844
Other administrative expenses	2,554
TOTAL (agree to Schedule V, line 17, col. 3)	$ 194,398
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 1,462
Dole Law Offices	Legal	137
Davis & Campbell	Legal	1,455
FR & R Healthcare	Consulting	550
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,604

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,784
Unemployment Compensation Insurance	24,000
FICA Taxes	169,610
Employee Health Insurance	150,750
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	7,661
Employee Physical	1,060
Workman's compensation Medical Expense	137
Employee Uniforms	(5)
Home Office Allocation	18,815
TOTAL (agree to Schedule V, line 22, col.8)	$ 446,812

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,524
Health Care Worker Background Check	
(Indicate # of checks performed)	
Software Support	3,815
Subscriptions	553
Miscellaneous Fees & Licenses	1,218
On Line Fees & Support	1,098
Life Services Network	5,399
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,607

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 146
In-State Travel	8,623
Seminar Expense	7,005
Meals/Miscellaneous	5,169
Home Office Allocation	6,413
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27,356

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 2002 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $5,399**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,970** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,677**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **996**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided when completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Beulah Land Christian Home
Allocation on Benefits 6/30/2003 kdb
11/4/2005

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	Benefit Percentage	W C Med Expense	Employee Uniforms	Employee Expense	Employee Physicals	
117,175.68	16,476.00	51,336.00	103,500.00						
13,939.67	2,376.00	7,416.00	9,000.00	7,504.16					
11,621.29	2,088.00	6,516.00	5,250.00	6,338.49					468,206.13
3,085.83	396.00	1,224.00	4,500.00	2,495.84					
8,789.08	1,476.00	4,584.00	15,375.00	4,849.13					
13,540.58	936.00	2,928.00	9,000.00	18,107.49	136.90				
1,457.75	252.00	780.00	4,125.00	914.08		-5.00	7,661.16	1,060.00	
169,609.88	24,000.00	74,784.00	150,750.00	40,209.19	136.90	-5.00	7,661.16	1,060.00	468,206.13

Less Benefits: 40,209.19
Line 3.22.3 427,996.94

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